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Patient Information Form

Mr./Mrs./Ms./Dr. _____

Address: _____

Phone #: (put a * next to preferred contact number, where a message may be left)

(home)_____

(work)_____

(mobile)_____

(___check here to permit texting about an appointment)

Email (optional, and permitting contact about appointments)_____

Marital/partnership status: _____ Date of Birth: _____

Household members (name, relationship, date of birth):

Employer: _____ position: _____

And/or

Current school: _____ year/grade: _____

Years of Education/Degree_____

Referred by/Knew about from: _____

Please initial here _____ if you consent to my thanking the referral source (if applicable)

Primary care physician: _____ Phone #: _____

Medical conditions or allergies: _____

Medications: _____

Date of last medical exam/evaluation: _____

Prior therapy? ___ no ___ yes with whom? _____ when? _____

Emergency contact (name and phone #): _____

Financial responsibility for psychological services (if different from patient)

Responsible party: _____

Address, if different from patient: _____

phone #, if different from patient:

(H)_____

(W)_____

(mobile) _____